KANSAS
DIVISION OF HEALTH POLICY AND FINANCE
ROBERT M. DAY, DIRECTOR KATHLEEN SEBELIUS, GOVERNOR

Testimony on:
Current MMIS Project Updates

presented to:
Joint Committee on Information Technology

by:
Scott Brunner
Division of Health Policy and Finance

January 6, 2006

For additional information contact:
Luke Thompson
Division of Health Policy and Finance

Landon State Office Building
900 SW Jackson Street, Suite 252
Topeka, KS 66612
Phone: 785-296-3512
Fax: 785-296-3468

Docking State Office Building
915 SW Harrison Ave., Room 651-S
Topeka, KS 66612
Phone: 785-296-3981
Fax: 785-296-4813

Kansas Division of Health Policy and Finance
Robert M. Day, Director

Joint Committee on Information Technology
January 6, 2006

Current MMIS Project Updates

Mr. Chairman and members of the committee, I am Scott Brunner, Medicaid Director for the Division of Health Policy and Finance. I am here today to provide updates on projects to enhance the Medicaid Management Information System (MMIS) due to federal policy changes and the reorganization of the Medicaid program.

Currently there are two approved information technology projects, which will implement enhancements on the Kansas Medicaid Management Information System (MMIS). Both of these projects will implement federally required changes to the MMIS and have been approved by the Chief Information Technology Officer (CITO) and by the Centers for Medicare and Medicaid Services (CMS) for enhanced federal funding.

National Provider Identifier Project:

Part of the national Health Insurance Portability and Accountability Act (HIPAA) of 1996 was the enactment of a National Provider Identifier (NPI). The final rule for the NPI portion of HIPAA was published January 23, 2004.

The NPI is intended to uniquely identify a health care provider in standard transactions, such as health care claims. NPIs may also be used to identify health care providers on prescriptions, in internal files to link proprietary provider identification numbers and other information, in coordination of benefits between health plans, in patient medical record systems, in program integrity files, and in other ways.

HIPAA requires that covered entities (i.e., health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions by the compliance dates. The compliance date for all covered entities except small health plans is May 23, 2007; the compliance date for small health plans is May 23, 2008. As of the compliance dates, the NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions by covered entities.

Kansas Medicaid is subject to these requirements and thus must be prepared to accept and use the NPI by the compliance date of May 23, 2007. As the Centers for Medicare and Medicaid Services (CMS) have already begun to issue NPIs (as of May 23, 2005), we also plan to accept and store these identifiers if providers begin to place them on electronic claim transactions.

This project modifies the MMIS claims payment system to allow Kansas Medicaid to use the NPI. The MMIS will then correctly identify providers and process their payments accordingly. The project will be implemented in two phases. Phase 1 will implement the capture and storing of NPI for later use in Phase 2. Phase 2 will implement the end-to-end processing of transactions using the NPI. Phase 1 will also include design of the changes needed to process claims using the NPI.

Project Update:

Since the committee last met in September, activity on Phase I of this project has begun in earnest. EDS has hired a project manager by contracting with a company called ForeThought Group. The manager came on board in October. The project schedule provided by the project manager has been approved by DHPF staff and several deliverables for Phase I currently are under review. State staff are busy with design sessions for Phase I and will soon begin participation in design sessions for Phase II.

We anticipate completion of Phase I by August 2006. Phase II will then be completed no later than May 23, 2007 in order to meet the federal HIPAA requirement. In August, CMS approved the project as described, including the application for enhanced federal matching funds. The project has a proposed budget of $2,540,223, including $254,022 in state funds. It is estimated that Phase II will cost $4,700,000 in all funds. The project is on budget.

Medicare Part D MMIS Project:

The Medicare prescription drug benefit, known as Part D, began on January 1, 2006. This program affected Medicaid beneficiaries that also are eligible for Medicare due to age or disability. The most significant aspect of this new program for these "Dual Eligibles" is that prescription drugs will be paid by Medicare rather than Medicaid. Beneficiaries will have to enroll, or be auto assigned, in a Prescription Drug Plan to receive coverage.

The second aspect of the program is some beneficiaries may be eligible to receive a subsidy to pay for a portion of their Medicare Part D premium.

Implementing this program required changes to the MMIS system. The MMIS system must be modified to deny prescription drug claims for Medicaid recipients who are eligible for Medicare Part D coverage and meet various other federal requirements related to the Medicare Part D Program. If the agency doesn't make these changes to the MMIS system, the State will pay all the related prescription drugs from all state funds since federal match will no longer be available (approximately $79.0 million annually).

Project Update:

The policy was implemented on January 1, 2006 as scheduled. We are also participating in the CMS contingency plan for dual eligible individuals. CMS has developed a point of sale solution to ensure full dual eligible individuals do not experience any coverage gap

when their Medicaid drug coverage ends, and their Medicare Part D coverage starts on January 1, 2006. Beneficiaries who present evidence of both Medicaid and Medicare eligibility but are not enrolled in a Part D plan, can have their prescription filled pending enrollment. A CMS contractor, Z-Tech will follow up to validate eligibility and facilitate their enrollment in a Part D plan. Z- Tech has been given access to the Kansas MMIS to access eligibility information.

The project was approved by CMS for enhanced funding. The total cost of the project was budgeted at $325,537, including $32,554 from the State General Fund.

The policy was implemented in time for the January 1 implementation deadline.

MMIS Changes related to Reorganization

The Kansas House Substitute for Senate Bill 272 designates the Division of Health Policy and Finance (DHPF) as the single State Medicaid agency. To accommodate the change, the MMIS, the provider and beneficiary Internet site, and required documentation must be updated. EDS estimates 8,733 hours of systems, business, and testing work will be needed to make these changes and recommends the addition of a technical project manager for the following reasons:

- Financial reporting and assignment of program cost account (PCA) codes must be updated.
- Each occurrence of SRS must be reviewed manually to determine if SRS should remain when referencing programs such as waiver or if DHPF or new agency name should be replaced. Since this is a human decision making point, no automatic review can be done to do a complete review and replace.
- All interfaces with existing agencies must be retested to ensure that PCA codes are operating as expected.
- A spreadsheet of all documentation and publications that need to be updated with the name change was attached to the estimate. This includes hundreds of places to review and change such as all information on the Internet, identification cards, and similar items.
- Adding additional design to allow drug rebate to view PCA codes to credit the proper state agencies with the rebate amount.

Based on historical information, EDS' original contract proposal assumed a routine use of 53,345 hours for systems maintenance, modification, and testing. DHPF could choose to use 8,733 of these hours to perform the changes needed for the reorganization instead of acquiring additional staff. However, this choice would result in fewer resources being available for other MMIS work such as new policy implementation.

Project Update:

As new information becomes available, EDS continues to revise the estimate of work needed to complete changes related to the creation of the Division of Health Policy and Finance as the single State Medicaid agency. A revised estimate is expected the week of January 3rd.

Electronic Prescriptions:

The 2005 Legislature approved a proviso in the final appropriations bill, HB 2482, requiring Medicaid to modify the MMIS for implementation of an electronic prescription system. These modifications are to include components to provide information on non-Medicaid eligible prescriptions to recipients to assist in access to free or reduced cost drugs. We are still in an information gathering stage to respond to this Legislative directive. We have had preliminary discussions with EDS on the impact of electronic prescription submission on existing claims processing and the technical requirements of receiving and processing "e-prescriptions." There are several companies that offer e-prescribing as a stand alone product or as part of a pharmacy benefit management, medical practice management, or electronic health record application. Competitive bidding should be considered as an option to ensure the State is getting the best solution, technologically and financially.

There is a national discussion about the standards for electronic prescriptions and electronic, interoperable health records. The Medicare Modernization Act of 2003 (MMA) charged CMS with the responsibility for creating standards for electronic health records. In July, CMS announced an electronic drug prescribing initiative to accelerate the nationwide adoption of e-prescribing for Medicare beneficiaries. The MMA requires e-prescribing based on national standards for drug plans participating in the new Medicare Part D prescription drug benefit by 2009. CMS also is developing an initial set of standards for January 2006 when the Medicare benefit begins.

DHPF is monitoring the national discussions of standards for electronic health records, including electronic prescriptions. As with other federal requirements, Medicaid will comply with any regulatory direction that affects Medicaid beneficiaries or MMIS operations. The difficulty is in identifying the role of the MMIS in assisting with electronic prescriptions. Most of the available and proposed electronic prescription systems create a connection between a prescriber and a pharmacy. The MMIS does not currently have an interface that is available to prescribers, like a primary care doctor, that can transmit a prescription to a pharmacy. The MMIS is designed to process claims, which are specific to one provider, and to exchange information among a variety of data systems for eligibility, provider enrollment, and service utilization management. An electronic prescription is not a claim, but it is information that could be shared among providers with the appropriate interface, data transmission, and security controls. The current MMIS is not designed to connect providers to each other, but the infrastructure could be built as a separate module to interact with the claims processing and provider enrollment information that already exists. We continue to explore the possibility of e-prescribing, recognizing that the federal government is developing standards and that this discussion fits into the development of a more comprehensive electronic medical records system.

Project Update:

We continue to monitor the national discussions related to the establishment of standards for electronic health records, including e-prescribing. The expected changes related to Medicare Part D have not been released although CMS has released electronic medical

record software to physician practices that contains basic electronic prescription capability.

DHPF also is pursuing a pilot project with our HealthWave managed care organization, FirstGuard, to create a Community Health Record. This effort would create an interoperable health record among health care providers, including the capability for electronic order entry and e-prescribing. The target implementation date is June 2006.